STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013253	A. BUILDING: _____ B. WING _____	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AXELACARE HEALTH SOLUTIONS LLC	450 E 96TH STREET, SUITE 500 INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was an initial home health state licensure survey. Survey dates: July 2 and July 3, 2014 Facility # 013253 Surveyor: Nina Koch, RN, Public Health Nurse Surveyor Census: 7 Records Reviewed: 4 Home visits: 1 Axelacare Health Solutions was found to be in compliance with the state rules for home health licensure 410 IAC Article 17. Quality Review: Joyce Elder, MSN, BSN, RN July 11, 2014	N 000		